RETINA CENTERS OF ALABAMA

Name: _____ DOB: ____/____/_____

Occupation: _____ ☐ Retired Education: _____

Tobacco Use: __None __Past Use __Current Use If current cigarette use, # ____ packs per day, for # _____ years

Alcohol Consumption: __Yes __No How many drinks per week? _____

Do you currently exercise? __Yes __No How often _____ Exercise Type _____

Do you drive? __Yes __No Do you feel your vision is good enough for safe driving? __Yes __No

Do you live alone? __Yes __No Do you have a Living Will? __Yes __No Do you have an Advance Directive? __Yes __No

Do you take aspirin/blood thinners? __Yes __No

MEDICATIONS (Prescription & Non-Prescription including herbal supplements)

Medication	Strength / Frequency	Medication	Strength / Frequency

ALLERGIES **__No Known Allergies**

Medication	Reaction	Medication	Reaction

Do you have any other allergies? (i.e. foods, dyes, environmental, bee stings)? __Yes __No _____

Have you ever had an allergic reaction to latex? __Yes __No _____

Do you have a history of asthma, hay fever, or eczema? __Yes __No

IMMUNIZATIONS

Tetanus ___ Flu (Influenza) ___ COVID (coronavirus) ___ Pneumovax ___ Hepatitis B ___ Shingles (Zoster) ___

Do you see any other specialists on a regular basis? If yes, please list name and specialty

Name	Specialty	Name	Specialty

FAMILY MEDICAL HISTORY

Have any relatives been diagnosed with any of the following? If yes, please indicate the family connection (i.e. mother, son, etc.)

☐ Macular Degeneration _____ ☐ Diabetes _____

☐ Retinal Disease _____ ☐ Heart Disease _____

☐ Glaucoma _____ ☐ Cancer _____

☐ Autoimmune Disease _____ ☐ Neurological Disease _____

CURRENT MEDICAL PROBLEMS/CONDITIONS

Problems/Conditions	Date of Diagnosis

PAST MEDICAL HISTORY – MEDICAL CONDITIONS/HOSPITALIZATIONS/SURGERIES

Medical Conditions/Hospitalization/Surgeries	Date

Do you have, or have you had any of the following:

☐ Heart disease ☐ Stroke ☐ Thyroid disease ☐ Asthma ☐ Ankylosing spondylitis
☐ Carotid artery disease ☐ Paralysis ☐ Diabetes ☐ Emphysema ☐ Rheumatoid arthritis
☐ Heart stents ☐ Migraines ☐ Blood disorder ☐ Sarcoidosis ☐ Degenerative arthritis
☐ Open heart surgery ☐ Optic neuritis ☐ Anemia ☐ Acid Reflux ☐ Lupus
☐ Pacemaker ☐ Peripheral neuropathy ☐ Prostate Disease ☐ Hiatal hernia ☐ Myasthenia gravis
☐ Valve replacement ☐ Multiple Sclerosis ☐ Kidney disease ☐ Crohn's Disease ☐ Hepatitis
☐ Peripheral vascular disease ☐ Parkinson's ☐ Dialysis ☐ Ulcerative colitis ☐ Tuberculosis
☐ High blood pressure ☐ Severe trauma ☐ Cancer ☐ Skin disorder ☐ Lyme disease

Have you been experiencing any of the following:

☐ Headaches ☐ Chest pains ☐ Fevers ☐ Shortness of breath ☐ Frequent Cough ☐ Excessive bleeding ☐ Weight loss
☐ Hearing loss ☐ Memory loss ☐ Heartburn ☐ Frequent urination ☐ Excessive thirst ☐ Diarrhea ☐ Blood in urine or stool
☐ Loss of sensation ☐ Numbness/Tingling ☐ Frequent falls